first 15 minutes. Thereafter, those indicating high risk behaviour together with a comparison group of similar size were subjected to a longer, more detailed interview.

The British used face to face interviewing to gather unthreatening information, and then with characteristic British discretion proceeded to ask more sensitive questions by means of printed cards, and with the really difficult ones, concealment of the answers in an envelope. The development of these techniques makes interesting reading.[6-8] Although in the first British pilot study, only 0·5% of men admitted some homosexual experience, in the main study 6·1% in Britain and 11·9% in Greater London did so. No doubt the interview method had been improved, but how much further scope for improvement is there? To what extent does the reported association between multiple partners and higher socio-economic status reflect differing degrees of preparedness to reveal?

No one is likely to reveal all about their sexual experiences. The threat of disclosure is often as much to do with one's partner or family finding out as with releasing information to the researcher or "the state." Nevertheless, we can justifiably conclude, from these and other recent studies, that much of the population will reveal to a reasonable extent. The reasonableness probably depends on there being a good, adequately explained purpose, and sound security in its confidentiality. Both factors depend on the quality of the relationship between interviewer and subject, however brief. It is therefore remarkable how little has been said, by either group, about the interviewers and their training. There is also scant information about the form of questions.

These and other recent studies therefore raise as many questions as they answer. Their usefulness in combating the HIV epidemic is not yet clear. But, undoubtedly, they should be welcomed. In addition to the evidence obtained, a wealth of experience in investigating sexual behaviour has been gained in a short period of time. The various research groups should pool and share their experience and provide a sound basis for future research on this topic.

Although by far the largest, this is the third wave of research into sexual behaviour in the past 30 years or so. Each wave has been driven by particular concerns. In the 1960s it was concern with the extent of premarital intercourse and the seeming threat to moral standards and the institution of marriage, resulting in what has been called a "virginity census."[9] In the 1970s it was concern about the alarming rate of teenage pregnancies, particularly within the United States.[10] Now it is the threat of AIDS. In each case the research can be criticised for its limited scope, focusing on counting rather than understanding. (A cross cultural study of teenage pregnancy is a valuable exception in this respect.[11])

If sex research is to make a worthwhile impact on the HIV epidemic, as well as other crucial issues of social and health concern (for example, the regulation of fertility), more attention will need to be given to studying why people put themselves at risk. This is already happening in relation to homosexual behaviour.[12] We may obtain such information, relevant to heterosexuality, from another large privately funded American study, which is now in the analysis stage and which, among other things, examines the nature of the relationships between sexual partners.[13] Such research does not necessarily require large scale surveys, but it does require properly developed research techniques. Maybe, with the "kickstart" of this recent wave, we will see the official recognition and maintenance of a research tradition that will allow us to continue necessary studies into the future in a less frantic fashion.

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Reed report on mentally disordered offenders

They need health and social services, not prison

How serious are the government's intentions to improve services for mentally ill offenders? In *The Health of the Nation* health authorities are required to include mentally disordered offenders in their strategic and purchasing plans.[1] The government has now published the final report of a joint review by the Home Office and Department of Health of services for mentally disordered offenders and others requiring similar services.[2,3] The committee, chaired by Dr John Reed, senior principal medical officer at the Department of Health, began its work in January 1991. Consultation papers on community, hospital, and prison services were issued in November 1991,[4] and papers on finance, staffing, research, and academic developments followed in June. The final report draws together the conclusions of the consultation papers and makes 276 recommendations. It applies to services in England. The Welsh Office is currently considering responses to its report on forensic psychiatry services produced earlier this year.[5] In Scotland there has been no comparable review.

Underlying Reed's report are clinical scenarios for which medical responses are rarely adequate. When the police apprehend a disturbed young man suffering from schizophrenia what action might they reasonably expect from medical agencies? How long should a psychotic offender, remanded in prison for a psychiatric report, wait until a psychiatrist for the catchment area comes to see him? When a patient detained in a special hospital is considered ready for transfer to another hospital how long should he have to wait before it takes place?

Reed rightly proposes that these and other needs can be met

only by a broad and integrated range of health and social services. The principles espoused by Reed are that high quality care should be provided by health and social services (not in the criminal justice system) according to individual need, near to the patient's home or family, as far as possible in the community but otherwise in conditions of no greater security than is justified; the ultimate aim should be to maximise rehabilitation or opportunities for independent living.

A multiagency approach and local ownership of services are seen as crucial. Most mentally disordered offenders should be cared for by general psychiatry and learning disability services, with access to more specialised resources when necessary. There should be an expansion, and wider range, of community based facilities. A stronger academic and research base should be established to underpin developments and play a key part in training.

The Reed report has profound implications for the government, patients, doctors, and managers. The government must decide what it will accept and fund. The report is impressive because it is comprehensive. It cannot be implemented in whole overnight. (Where, for example, are 175 new psychiatrists and 80 forensic psychiatrists to be found?) But its recommendations are interdependent, and large chunks cannot simply be jettisoned. For example, what use are the 900 extra places in regional secure units proposed by Reed if there are no appropriate facilities for aftercare? What value is a nationwide system of court diversion schemes if there are no beds to which patients can be diverted?

The chief implication for patients is that they should not be disadvantaged by their status as offenders. General practitioners and psychiatrists will need to accept that at times some mentally disordered patients may be violent, for that is the nature of serious mental disorder whether in patients suffering their first episode of schizophrenia,[6] long stay patients newly settled in the community,[7] or mentally ill residents in hostel accommodation.[8] These patients do not forfeit their entitlement to care by manifesting features of their illness.

The Reed report will tax the ingenuity of managers in the NHS and in local authorities. It has not priced its recommendations, but emphasises the need to consider the costs to all agencies of "misplaced" patients and the costs incurred by denying early intervention. It emphasises the pernicious financial disincentives that influence agencies to deflect responsibility for mentally disordered offenders. Such a patient in prison or special hospital costs a district health authority nothing. It therefore proposes that each district health authority should accept financial responsibility for all the health care needs of its mentally disordered offenders (in common with the rest of its citizens) even if they are receiving specialist treatment outside the authority's boundary. In planning services, NHS managers will need to work closely with general practitioners, local authorities, and agencies in the voluntary sector and criminal justice system. Regional health authorities, too, have crucial roles in conducting assessments of need, ensuring the provision of services, and monitoring standards.

Is it possible at this early stage to spot any green shoots of growth in services? The government would point to some pilot projects to divert people from court and to its increase in capital funding for medium secure facilities for 1992-3. It has also announced the establishment for three years of a national advisory committee to follow up action on the Reed report. On the negative side, 53% of purchasers and 54% of providers recently surveyed by Blumenthal and Wessely had no current or future plans for schemes to divert people from courts.[9]

Can the massive exercise in multiagency working which Reed proposes be implemented? It comes at a time of economic recession and when agencies are struggling with new funding arrangements and new roles. Some, such as the regional health authorities, face an uncertain future.[10] We can see clearly the requirements for mentally disordered offenders, and Reed has done a masterly job in presenting them. But will the operation get afloat? Or will complex bureaucracy, the market economy in the NHS, and inadequate funding leave it dead in the water? We must hope not.

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A national standard for entry into general practice

Practical and symbolic benefits

A national standard of entry into general practice—under consideration by the Joint Committee on Postgraduate Training for General Practice[1]—has important implications for all of general practice but particularly for vocational training. It puts general practice on the same footing as other specialties.

If the recommendations of the working party set up to advise the joint committee are accepted, then knowledge, performance during consultations, practical and management skills, and ability to audit will be taken into account together with trainers' overall assessments. No final summative assessment (end point assessment with set standards) has yet been agreed, but, if a standard for entry is to be set and a certificate which determines competence awarded, it is hard to avoid the need for one.

Knowledge is best assessed by multiple choice or modified essay questions; why the working party thought that this should be set and applied locally is hard to fathom. The multiple choice questionnaire and written component of the examination for the MRCGP are already accepted by most trainees, academic departments of general practice, and general practice partnerships as a national standard of written knowledge.[2] The examination's timing and purpose as an end